Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth

Eligibility Operations Memo 06-05
April 15, 2006

TO: MassHealth Eligibility Operations Staff

FROM: Russ Kulp, Director, MassHealth Operations

RE: **Uncompensated Care Pool (UCP) Streamlined Annual Review Process**

Introduction

In October 2004, MassHealth started processing Uncompensated Care Pool (UCP) eligibility determinations in MA21 for the Waiver applicants (see "Population Affected" below).

MassHealth will now review active UCP households through a streamlined "profile" review process similar to all the other annual review processes in MA21. A new simplified UCP eligibility review form has been created to capture the necessary information. Members will have 60 days to return the completed form.

UCP members whose eligibility was determined through a hospital or community health center desktop application are not included in this streamlined review process. To be chosen for this review, the household must reside in MA21. These UCP members must submit an initial Virtual Gateway application or Medical Benefit Request (MBR) to be included in future streamlined reviews.

Population Affected

The Waiver population is the new term describing members eligible under Volume I regulations. These members were formerly known as the Health Care Reform population. The regulations remain the same. The change is necessary to eliminate any confusion with other health-care initiatives called Health Care Reform.

The population for this review process will be Waiver applicants denied for a MassHealth benefit and who are currently active with a UCP benefit type (UC and UP). Households where all members have a UCP benefit will be selected. Mixed households that have UCP and other MassHealth benefits will be bypassed. They will be selected by the regular annual review process. Other criteria for bypassing UCP households include:

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Population Affected (cont.)

- households where there is an existing work order (such as, waiting to be determined because of outstanding verifications);
- members aged 64 years and 10 months or older; and
- Waiver households that have a member aged 65 or over.

UCP members aged 64 years and 10 months will be selected in the transition profile select and they will be sent the green MassHealth Eligibility Review (MER) to prepare them for a Traditional eligibility determination.

Waiver households that have members aged 65 or over will be identified on a report and will be handled by staff at Central Office.

Later in the year, a separate profile process will be used for UCP members who have applied for MassHealth under Traditional rules.

UCP Eligibility Review Form

The new form is called the Uncompensated Care Pool Eligibility Review Form. It asks specific questions that may impact UCP eligibility. The compact design of this review form was created so it can be processed in an expedited manner. It asks what the current income is and if any members have left or joined the household within the past 12 months.

The UCP Profile

After households have been selected as part of the UCP profile review in MA21, each household will receive the following items in their profile select package:

- cover letter (UCP-H-Review-CL), introducing the review and giving the return date;
- UCP-H-Review form;
- green self-addressed, stamped envelope; and
- UNIV-5 (multilingual sheet).

A copy of the cover letter will also be sent to anyone listed on an Eligibility Representative Designation (ERD) form or Permission to Share Information (PSI) form and on MA21.

The cover letter includes the names of all the members of the household who are being reviewed for UCP. The review form asks the member to refer to the names listed on the cover letter, ensuring that all UCP members are included in the review.

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Systems Impact

The PRF event in MA21 shows the profile activity for the entire household. The UCP annual profile process is identified as "UCP Annual" in MA21. All the profile functions remain the same. Households will close for Action Reason 41 (failure to return the review form) if the review is not received by the due date.

UCP Review Team and MEC Responsibilities

Intake of UCP Review Forms
A UCP Review Team at the Charlestown office will process these reviews.

The review forms can be mailed or faxed to:

MassHealth UCP Review Team
P. O. Box 290794
Charlestown, MA 02129-0214
1-800-795-1922
TTY: 1-800-723-7779 (for people with partial or total hearing loss)
Fax: 617-241-6005

The UCP Review Team has a special toll-free UCP hotline set up with Automatic Call Distribution (ACD) phone features to receive phone calls from members and providers. Members and providers can call if they need another form, have questions about a form that has been mailed, or to request a form in Spanish. All other calls not related to the UCP review process, especially eligibility-related calls, will be directed to the MassHealth Enrollment Centers (MECs).

Maintenance During the Profile Process
The MECs will handle customer service inquiries by phone or walk-in and perform maintenance functions to UCP households in MA21. If a member is in an active UCP profile status and reports changes that may make them eligible for a MassHealth benefit, the UCP profile is released by the MEC. Once the profile is released, the changes can be entered and a full MassHealth determination can be made. MEC staff can release households from UCP profiles by using the PF6 option in the PRF event. The household will be included in the next profile select.

Member Requests Another UCP Review Form
If a member requests another form and is still active in the profile, MEC staff or the UCP review team can release the household from the profile using the PF6 option in the PRF event. The household will be included in the next profile select and MA21 will send another review form.

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UCP Review Team and MEC Responsibilities (cont.)

Expired or Closed UCP Profiles
If the member does not return the review form on time, or the case is closed for Action Reason 50 (whereabouts unknown), a new Virtual Gateway application or MBR needs to be completed. The UCP Review form will not be accepted.

Incomplete UCP Review Forms
It is possible that members will return their review form with missing critical information, such as a new member's birth date or gender. If the missing information cannot be obtained after trying to contact the household, an eligibility determination can be done without adding the new member. A message is then recorded in the NTH event that explains why the member could not be added.

Attachments

Attached to this memo are the:

- Uncompensated Care Pool Eligibility Review Form; and
- Uncompensated Care Pool Eligibility Review Form cover letter that accompanies the review form.

Questions

If you have any questions about this memo, please have your MEC designee contact the Policy Hotline.

Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

MassHealth/UCP Review Team
P.O. Box 290794
Charlestown, MA 02129-0214

<Date: _____>

<SSN: _____>
<MEC: _____ PrfID: _____>
<NUM: _____ Type: _____>

<Member's Name>
<Street Address>
<City, State, Zip>

IMPORTANT

A NOTICE ABOUT YOUR MASSHEALTH/UNCOMPENSATED CARE POOL (UCP) ELIGIBILITY REVIEW

The member(s) listed below have been selected as part of the MassHealth/UCP eligibility review that we do once a year.

Name: **SSN:**

Name: **SSN:**

Enclosed is a review form that you **must fill out** and **send back to us right away**. You need to fill out this form so we can decide if you can still get MassHealth/UCP. You may still be able to get MassHealth/UCP, even if your income has changed. Please send the filled-out, enclosed form and all needed information to the address below.

MassHealth/UCP Review Team
P.O. Box 290794
Charlestown, MA 02129-0214

Important

If you do not fill out this form and send it to us by: <_____,> your MassHealth /UCP may stop, and the UCP may not be able to pay for services for you or members of your household at participating hospitals and community health centers. It is VERY important to send back all requested information to the address above by the above due date so that you do not lose your benefits. We will send you a written notice if there are any changes to your MassHealth/UCP benefits. If you do not get a written notice from us, that means there are no changes to your benefits.

The information you give us will be kept confidential, as required by state and federal law.

If you have any questions, need a copy of the form in Spanish, need help filling out the form or getting the information you need, or want a voter registration form, call the MassHealth Enrollment Center at the telephone number below.

Toll-free number: 1-800-795-1922
TTY phone number: 1-800-723-7779 (for people with partial or total hearing loss)

MassHealth

Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

Uncompensated Care Pool Eligibility Review Form

For office use only (WAIVER)

Date received:

You and members of your household were determined to be eligible for full or partial payment of your medical bills at a hospital or community health center under the Uncompensated Care Pool (UCP). The answers on this review form will be used to find out if you are still eligible to have your health-care providers' charges paid by the UCP.

The information you give us is kept confidential, as required by state and federal laws.

Please answer all questions and fill out all sections that apply to you and your household. If you need more space in any section, give us the information on a separate sheet of paper and attach it to this review form.

If you have any questions about this review form or the information you need to send, please call the MassHealth/UCP Review Team at 1-800-795-1922 (TTY: 1-800-723-7779 for people with partial or total hearing loss).

Head of Household Information

HOH

Last name	First name	MI	Street address

City	State	Zip	Mailing address *(if different from street address or if living in a shelter)*

Social security number*	Date of birth	Gender
	/ /	☐ Male ☐ Female

Race *(optional)*	Spoken language	Written language	Ethnicity *(optional)*

Telephone numbers *(List work number only if we can call you at work.)*

Home: ( ) Work: ( )

Other Household Members Information

HOH

Please answer the following questions. **(Note: When filling out this section, please look at the cover letter (that was sent with this form) that lists the members of your household you listed on your original application.)**

- How many members are living in your household now? _____ (This number includes you, your spouse, and any dependents under age 19 now living with you.)
- Have any new members joined your household in the past 12 months? ☐ yes ☐ no

If **yes**, fill out this section.

Name	Is this person applying?	Social security number*	Date of birth	Gender	Relationship to head of household
	☐ yes ☐ no		/ /	☐ Male ☐ Female	
	☐ yes ☐ no		/ /	☐ Male ☐ Female	

- Have any members left your household in the past 12 months? ☐ yes ☐ no

If **yes**, fill out this section.

Name	Social security number*	Date of birth	Gender	Relationship to head of household
		/ /	☐ Male ☐ Female	

*List only if one has been issued.

Fill out the Working and Nonworking Income Information sections on the other side of this page, then sign and date the form.

Working Income Information

EIN

▶ List the working income for you or any family member in the section below.

☒ **Send proof** of income, like a copy of two recent pay stubs, a copy of your most recent federal tax return with attachments, or a statement from your employer.

1. **Name**

Employer name, address, and telephone number	Type of work *(Check all that apply.)*			**For office use only** (indicate weekly, biweekly, or monthly)	
	☐ full-time ☐ part-time ☐ self-employed	☐ day labor ☐ seasonal yearly wage: $ _____	☐ sheltered workshop yearly wage: $ _____	$	
				$	

Is health insurance offered?*	Number of hours per week	Weekly pay before deductions	Date began getting this amount of pay	HID		
☐ yes ☐ no		$	/ /		Hrs.	
					Hrs.	

2. **Name**

Employer name, address, and telephone number	Type of work *(Check all that apply.)*			**For office use only** (indicate weekly, biweekly, or monthly)	
	☐ full-time ☐ part-time ☐ self-employed	☐ day labor ☐ seasonal yearly wage: $ _____	☐ sheltered workshop yearly wage: $ _____	$	
				$	

Is health insurance offered?*	Number of hours per week	Weekly pay before deductions	Date began getting this amount of pay	HID		
☐ yes ☐ no		$	/ /		Hrs.	
					Hrs.	

* Check yes even if you cannot get it now.

Nonworking Income Information

UIN

▶ List the nonworking income, like child support, unemployment compensation, rental income, or a pension, for you or any family member in the section below.

▶ Please describe the type and source (where it comes from) of the income for each family member.

☒ **Send** a statement from the source of the income. You do not have to send proof of social security or SSI income.

Name	Type and source (where it comes from) of income	Monthly amount before taxes	**For office use only**

Signature

I certify under penalty of perjury that the information on this form is correct and complete to the best of my knowledge. I understand that I must tell MassHealth of any changes in income or employment, family size, address, health insurance, and immigration status, or of changes in any other information given on this review form within 10 days of learning of the change.

I understand that MassHealth may check the information given on this review form with the Massachusetts Department of Revenue, the Social Security Administration, and/or other state and federal agencies.

The head of household, all persons aged 18 or older, and all parents of any age who have children living with them who are getting or want to get Uncompensated Care Pool benefits, must read this signature section carefully, then sign and date below. If you are signing below as an eligibility representative, a filled-out MassHealth Eligibility Representative Designation Form must also be submitted or already be on file with MassHealth.

_____ _____

Signature of member or eligibility representative Date

_____ _____

Signature of member or eligibility representative Date